

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>01/12/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANORCARE HEALTH SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1345 N MADISON AVE</b> <b>ANDERSON, IN 46011</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00160017 and IN00160549.</p> <p>This visit was done in conjunction with the Investigation of Complaint IN00161048.</p> <p>Complaint IN00160017 - Corrected</p> <p>Complaint IN00160549 - Corrected</p> <p>Survey dates: January 9 and 12, 2015</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 129 SNF: 25 Total: 154</p> <p>Census payor type: Medicare: 18 Medicaid: 100 Other: 36 Total: 154</p> <p>Sample: 4</p> <p>Manorcare Health Services was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the PSR to the Investigation of Complaint IN00160017 and</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 Complaint IN00160549.  Quality review completed by Debora Barth, RN.	{F 000}			